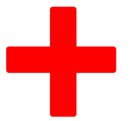
MEDICAL INFORMATION FORM



____ DATE______________

(YOUR LEGAL NAME)

Primary language________________ Able to Speak? __Yes __No

DATE OF BIRTH___________________________ SS#_____________________________________

ADDRESS ____

CITY____ STATE & ZIP_________________________

Male/Female_____ Height________________ Weight_________ Eye Color_____________

BLOOD TYPE_______________ ALLERGIC TO ____

____

____

>> SEE REVERSE SIDE OF THIS SHEET FOR MEDICATIONS & CONDITIONS <<

PRIMARY CARE DOCTOR________________________________ PHONE:_____________________

Hospital preference:____

Medicare #_____________________________________ Other______________________________

EMERGENCY CONTACT

NAME ____

RELATIONSHIP__________________________ PHONE___________________________________

CONDITIONS (Check all that apply.)

DATE:____________________

	Condition		Condition		Condition		Condition
	Pacemaker		Cataracts		High BP		Hard of hearing
	Defibrillator		Cataract surgery		Low BP		Low Vision
	Dentures		Heart Disease		Hypertension		Glaucoma
	Hearing aids		Heart attack		Hypoglycemia		Aids
	Glasses		Seizures		Alzheimer's		Cancer
	Hemophilia		Asthma		Dementia		Dialysis
	Diabetes		Anemia		Epilepsy		High Cholesterol
	Emphysema		Stroke				

PRESENT MEDICATIONS

NAME of MEDICATION	DOSAGE	FREQUENCY	DATE STARTED

DO YOU HAVE AN

___ Advance Directive or D.N.R. (Do Not Resuscitate)

Where is it located? ____